PLAN DOCUMENT

AND

SUMMARY PLAN DESCRIPTION

FOR

CITY OF HANNIBAL

AND

BOARD OF PUBLIC WORKS

DENTAL BENEFIT PLAN

Effective July 1, 2008

DENTAL PLAN
FOR
EMPLOYEES OF
CITY OF HANNIBAL AND BOARD OF PUBLIC WORKS

City of Hannibal and Board of Public Works has established a Dental Benefits Plan providing dental coverage for the benefit of eligible Employees of City of Hannibal and Board of Public Works and their eligible Dependents.

This Plan has been established and shall be maintained pursuant to a written instrument as required by Part 4 of Title 1 of the Employee Retirement Income Security Act of 1974 (hereafter referred to as "ERISA").

Effective September 1, 2007 the Dental Benefits Plan for eligible Employees of City of Hannibal and Board of Public Works (hereafter referred to as the "Plan") was restated as described in this document. The Plan will be administered according to the terms and conditions stated in this document and any changes made to this Plan must be in writing and must be approved and signed by the appropriate City of Hannibal and Board of Public Works representative.

In the event any provision of this Plan conflicts with the Non-Discrimination Rules or HIPAA, the Plan shall be deemed to be automatically amended so that it is in compliance with the Non-Discrimination Rules and HIPAA.

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SECTION I

INTRODUCTION

Every attempt has been made to explain the provisions of this Dental Benefits Plan in this Plan Document and Summary Plan Description. **Please read it carefully**. The Employer or the Claim Administrator will be happy to assist with any questions regarding benefits.

Certain words and phrases used in this document, along with the definition or explanation of the manner in which the term is used for the purposes of this Plan are listed in the Definition Section. These defined terms are capitalized throughout the document.

Note: The Employer reserves the right to terminate or amend this Plan at any time. Notification of any changes or of termination will be made available to participants of the Plan.

SECTION II

PROTECTED HEALTH INFORMATION

A. The Plan may disclose the following information to the Plan Sponsor without amending the Plan Document and Summary Plan Description (PD/SPD):

   1. Summary health information (information that summarizes claims history, claims expenses or types of claims without identifying the individual) may be disclosed to the Plan Sponsor for the purpose of:
      (a) obtaining premium bids from health plans for providing health insurance coverage under the Plan; or
      (b) modifying, amending or terminating the Plan.
   2. Enrollment or disenrollment information.

B. The Plan will only disclose Protected Health Information (PHI) to the Plan Sponsor (or provide for or permit the disclosure of PHI to the Plan Sponsor by a health insurance issuer or HMO with respect to the Plan) if the Plan has received certification from the Plan Sponsor that:

   1. The Plan is amended to incorporate the permitted and required uses and disclosures of PHI by the Plan Sponsor consistent with the Privacy Rules.
   2. The Plan Sponsor agrees to comply with the provisions of this Amendment.

C. The Plan Sponsor agrees to the following restrictions regarding the use and disclosure of a Covered Person's Protected Health Information (PHI):

   1. Only use or further disclose PHI for administrative purposes as permitted or required by the Plan Document and Summary Plan Description (PD/SPD) or the Privacy Rules.
   2. Ensure that any agents or subcontractors to whom the Plan Sponsor provides PHI will agree to the same restrictions that apply to the Plan Sponsor.
   3. Will not use or disclose PHI for employment-related actions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.
   4. Report to the Plan any use or disclosure of PHI that it is aware of that is inconsistent with those provided for in the PD/SPD.
   5. Allow Covered Persons to inspect and copy PHI about themselves in accordance with the specific guidelines contained in the Privacy Rules.
   6. Provide Covered Persons with the ability to amend or correct PHI about themselves in accordance with the specific guidelines contained in the Privacy Rules.
   7. Keep an accounting of its disclosures of a Covered Person's PHI in accordance with the specific guidelines contained in the Privacy Rules.
   8. Will make its internal practices, books and records relating to the use and disclosure of a Covered Person's PHI available to the U.S. Department of Health and Human Services.
   9. Return or destroy, if feasible, all of a Covered Person's PHI when no longer needed. If return or destruction is not feasible, the Plan Sponsor will limit further uses and disclosures to those purposes that made the return or destruction of the information infeasible.
   10. Ensure that the required separation between the Plan and the Plan Sponsor has been established and is maintained.

Forms needed to request access, restrictions or accountings are available in the Benefits office.

D. The required separation between the Plan Sponsor and the Plan:

1. The following is a list of Employees or classes of Employees or workforce members under the control of the Plan Sponsor who may be given access to Covered Persons' PHI received from the Plan (or from a health insurance issuer or HMO servicing the Plan):

   (a) City Clerk, City of Hannibal

   (b) Assistant City Clerk, City of Hannibal

   (c) Personnel Clerk, Board of Public Works

   (d) Chairman, Hannibal Employee Benefit Trust Board

2. This list reflects the Employees, classes of Employees, or other workforce members of the Plan Sponsor who receive Covered Persons' PHI relating to payment under, health care operations of, or other matters pertaining to Plan administration functions that the Plan Sponsor provides for the Plan. These individuals will have access to Covered Persons' PHI solely to perform these identified functions, and they will be subject to disciplinary action and/or sanctions (including termination of employment or affiliation with the Plan Sponsor) for any use or disclosure of Covered Persons' PHI in violation of, or noncompliance with, the provisions of this Amendment.

3. The Plan Sponsor will promptly report any such breach, violation or noncompliance to the Plan and will cooperate with the Plan to correct the violation or noncompliance, to impose appropriate disciplinary action and/or sanctions, and to mitigate any harmful effects of the violation or noncompliance.

SECTION III

SCHEDULE OF BENEFITS

The following chart summarizes benefit information. Please refer to specific benefit sections for more detailed explanations.

DESCRIPTION OF DENTAL BENEFITS	PLAN PAYS
Maximum Calendar Year Benefit (excluding orthodontia)	$1,000
Separate Lifetime Orthodontia Benefit Maximum	$1,000
Calendar Year Deductible • Individual	$50
• Family	$150
Diagnostic and Preventative Services • **Oral Exam** – two per Calendar Year • **Prophylaxis** – two per Calendar Year • **X-rays:** - **Bitewing X-rays** – limited to four films per Calendar Year - **Intraoral Periapical or Occlusal** – single films - **Extraoral Superior or Inferior Maxillary Film** - **Full Mouth Series** (at least 14 films, including bitewings if needed) – once every five Calendar Years - **Panoramic Film** – maxilla and mandible, allowable only when necessary to diagnose accident Injury, or in conjunction with cyst or tumor removal • **Fluoride** – once per Calendar Year for under age 14 • **Sealants** – once every three Calendar Years per tooth for under age 16 (limited to the unrestored permanent molars) • **Space Maintainers** – under age 16 (initial appliance only) • **Appliances to Inhibit Thumbsucking (**fixed and removable) – under age 16 (initial appliance only) • **Emergency Palliative Treatment and Other Non-Routine Unscheduled Visits** (only if no other service except x-rays is rendered during the visit	100% no deductible
Basic Services (6 month Waiting Period for Late Enrollees)	80% after deductible
Major Services (12 month Waiting Period for Late Enrollees)	50% after deductible
Orthodontia (24 month Waiting Period for Late Enrollees) Limited to Dependent children under age 19.	50% no deductible

SECTION IV

ELIGIBILITY, EFFECTIVE DATE AND TERMINATION PROVISIONS

A. EMPLOYEE COVERAGE

1. Eligible Classes of Employees

All Active Employees and Retired Employees as defined by the Plan.

2. Eligibility Requirements for Employee Coverage

A person is eligible for Employee coverage from the first day that he:

- is an Active Employee;
- is in a class eligible for coverage; and
- completes the employment Waiting Period (which begins on the date of employment and ends on the first day of the month following the date of employment) as an Active Employee.

3. Eligibility Requirements for Retired Employee Coverage

A person is eligible for Retired Employee coverage provided he:

a. is a Retired Employee under age 65, who retires under the formal written Retirement Plan of the Covered Employer;

b. is covered as an Active Employee on the day prior to his retirement; and

c. elects to contribute to the Plan the required contribution for Retired Employee coverage.

4. Effective Date of Employee Coverage

Employee coverage will become effective on the date that the Eligibility Requirement is met.

5. Rehiring a Terminated Employee

A terminated Employee who is rehired must satisfy the Eligibility Requirement again unless rehired within 90 days. However, an Employee returning to work directly from coverage under the Plan's COBRA continuation option need not satisfy the employment Waiting Period.

B. DEPENDENT COVERAGE

1. Eligible Classes of Dependents/Eligibility Requirement

Eligible Dependents include:

- An Employee's Spouse.
- An Employee's unmarried children, from birth up to the last day of the Calendar Year in which the child attains age 19, including natural children and Adopted Children. Children also includes Foster Children and stepchildren who are primarily dependent upon the Employee for support and maintenance.
  - If a Dependent is a Full-Time Student as determined by the Plan, unmarried and primarily dependent upon the Employee for support and maintenance, coverage will be extended up to the last day of the Calendar Year in which the child attains age 24. Proof of a Dependent's status as a Full-Time Student must be furnished to the Employer from time to time as may reasonably be requested. Proof must be acceptable to the Employer. Coverage will continue through the summer vacation period provided the Dependent is enrolled as a Full-Time Student for the fall semester (documentation will be required). If the Dependent does not actually return to school for the fall semester, coverage will terminate on the first day of the fall semester. Otherwise, coverage will continue to the end of the month when a Dependent ceases to be a Full-Time Student.

- Coverage will also be extended for unmarried Dependent children, regardless of age, who are Physically or Mentally Handicapped, classified as disabled before the limiting age and primarily dependent on the Employee for support and maintenance. To continue coverage for a handicapped child, proof of the handicap and dependency must be furnished to the Employer within 31 days after the last day of the Calendar Year in which the Dependent attains age 19 (or 24, if a Full-Time Student), and from time to time as may reasonably be requested. Proof must be acceptable to the Employer.

  "Dependent on the Employee for support and maintenance" means the Employee has a legal right to claim such child as a Dependent on his federal income tax form.

  Prior to the effective date of September 1, 2007 considered as the revised and/or restated document, Dependent children were covered up to the last day of the Calendar Year in which the child attained age 20, or the date the child attained age 26 if a Full-Time Student. Any Dependent child covered under the old age limitations will be allowed to continue coverage in accordance with the old age limitations.

- Children the Employee must cover under a Qualified Medical Child Support Order (QMCSO). A copy of the Plan's procedures governing QMCSO determinations may be obtained from the Employer at no cost.

These persons are excluded as Dependents:

- the legally separated or divorced former Spouse of the Employee;
- any person who is on active duty in any military service of any country; or

If a husband and wife are both Active Employees as defined by the Plan, they may elect to maintain separate coverage, or one may cover the other as a Dependent. However, an Employee cannot be covered as both an Employee and a Dependent.

If husband and wife are both covered as Employees under the Plan, their children will be covered as Dependents of the husband or the wife, but not both.

If a person covered under this Plan changes status from Employee to Dependent or Dependent to Employee, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for all amounts applied to maximums.

2. Enrollment Requirement for Dependent Coverage

Dependent coverage is contributory and the Employee must pay all or part of its cost. An Employee is required to enroll for Dependent coverage. Enrollment is making a written request for coverage and must be completed and signed by the Employee. The enrollment form will include a payroll deduction authorization.

- **Timely Enrollment** – The enrollment will be "timely" if the completed form is received by the Plan Administrator no later than 30 days after the Dependent becomes eligible for coverage.
- **Late Enrollment** – An enrollment is "late" if it is not made on a "timely basis." If an Active Employee does not enroll for Dependent coverage within 30 days of the Dependent's eligibility date, the Dependant may enroll at a later time, but only during an Annual Open Enrollment Period from May 1st through May 31st each year for a July 1st effective date as a late enrollee, unless the Employee experiences a change in family status as described in the Special Enrollments Provisions. The Annual Open Enrollment Period applies only to Active Employees. Retired Employees are not eligible for the Annual Open Enrollment Period.

Coverage terminated because a Dependent child no longer meets the Full-Time Student Status requirement will be reinstated when the Dependent again satisfies the Full-Time Student Status requirement; however, the Pre-Existing Condition Limitation will apply.

See Special Enrollments Provisions for additional enrollment information.

3. Contribution Requirement for Dependent Coverage

The Employer shall determine the portion of the cost of coverage to be paid by participants for Dependent coverage. This information will be communicated to Employees from time to time.

4. Effective Date of Dependent Coverage

Dependent coverage will become effective on the date that all of the following requirements are met:

- Employee is covered under the Plan;
- The Eligibility Requirement;
- The Enrollment Requirement;
- The Contribution Requirement.

5. Eligible Dependents of Retired Employees

Dependents of Retired Employees are subject to the same rules shown under the Dependent Coverage provision, and are eligible provided:

- they were a covered Dependent of the Active Employee on the day prior to his retirement (unless the Retired Employee experiences a change in family status as described in the Special Enrollments provisions); and
- the Retired Employee makes the required contributions.

C. SPECIAL ENROLLMENTS

- Employees who decline enrollment in this Plan (in writing if so required) for their Dependents due to other health coverage, may enroll their Dependents in this Plan at a later time if the other coverage is lost due to loss of eligibility, exhaustion of COBRA or termination of Employer contributions. Enrollment must be made within 30 days after the other coverage ends. Coverage will be effective on the date the other coverage ends.
- Employees who get married while eligible for coverage in the Plan may enroll the new Spouse as well as any other eligible Dependents not previously enrolled, provided enrollment is within 30 days of the marriage. Coverage for Spouse and other Dependents will be effective on the date of the marriage.
- Employees who acquire a child while eligible for coverage in the Plan may enroll the child as well as the Employee's Spouse and any other eligible Dependents not previously enrolled, provided enrollment is within 30 days of acquiring the new Dependent child. Coverage for the child and Spouse and other Dependents will be effective on the child's date of birth, date of adoption or date of placement for adoption.

D. TERMINATION OF COVERAGE

1. When Employee Coverage Terminates

Employee coverage will terminate on the earliest of these dates:

- the date the Plan is terminated;
- the end of the month the person ceases active work in an eligible class (this includes death or termination of employment).

2. Continuation of Coverage During Periods of Disability, Approved Leave of Absence or Layoff

A person may remain eligible for a limited time if active, full-time work ceases due to disability, approved leave of absence or layoff. This continuance of coverage for disability, approved leave of absence or layoff will end on the date on which all vacation and/or sick pay has been paid.

While continued, coverage will be that which was in force on the last day worked as an active Employee. Any changes in the benefits and/or the cost of coverage under this Plan will also apply to individuals who have continued coverage under this provision.

3. When Retired Employee Coverage Terminates

- the date the Plan is terminated;
- attainment of age 65, or the date of Medicare entitlement due to disability, whichever occurs first;
- the end of the month the person fails to make the required contribution.

4. When Dependent Coverage Terminates

Dependent Coverage will terminate on the earliest of:

- the date the Employee's or Retired Employee's personal coverage under the Plan terminates for any reason;
- the date Dependent coverage is terminated under the Plan;
- the date the Employee or Retired Employee ceases to have an eligible Dependent;
- as to any one person, the end of the month the person ceases to meet the definition of an eligible Dependent;
- the end of the month the Retired Employee's Dependent attains age 65;
- the end of the month the Employee or Retired Employee fails to make the required contribution.

E. UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT

Employees going into or returning from military service will have Plan rights mandated by the Uniformed Services Employment and Reemployment Rights Act. These rights include up to 18 months (24 months for elections made on or after December 10, 2004) of extended health care coverage upon payment of the entire cost of coverage plus a reasonable administration fee and immediate coverage with no preexisting conditions exclusions applied in the Plan upon return from service. If the leave is less than 31 days, the Employee is not required to pay more than he would have been required to pay if the Employee had not been on leave. These rights apply only to Employees and their Dependents covered under the Plan before leaving for military service.
Plan exclusions and Waiting Periods may be imposed for any Sickness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, military service.

F. FAMILY AND MEDICAL LEAVE ACT OF 1993 (FMLA)

During any leave taken under the Family and Medical Leave Act, the Employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

G. COBRA CONTINUATION OPTION

1. Overview

This provision contains important information about an Employee's rights to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available

when an Employee would otherwise lose his group health coverage. It can also become available to other members of the Employee's family who are covered under the Plan when they would otherwise lose their group health coverage.

Each Qualified Beneficiary (as defined below) who would lose coverage under the Plan as a result of a Qualifying Event (as defined below) is entitled to elect, within the election period, continued coverage under the Plan. COBRA coverage is identical to the coverage provided under the Plan to participants or beneficiaries who are not receiving COBRA.

2. Qualifying Event

For purposes of this provision only, a Qualifying Event will mean:

- with respect to a covered Employee, loss of coverage because of:
  - a reduction in the number of hours worked; or
  - termination of employment for any reason other than gross misconduct.
- with respect to a covered Spouse of an Employee, loss of coverage because of:
  - a reduction in hours of the Employee's employment;
  - termination of the Employee's employment for any reason other than gross misconduct;
  - divorce or legal separation from the Employee. Also, if the Employee reduces or eliminates his Spouse's group health coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event;
  - the death of the Employee; or
  - the Employee becomes entitled to Medicare benefits (Part A, Part B, or both).
- with respect to a covered Dependent child of an Employee, loss of coverage because of:
  - a reduction in hours of the Employee parent's employment;
  - termination of the Employee parent's employment for any reason other than gross misconduct;
  - Employee parent's divorce or legal separation;
  - the death of the Employee parent;
  - the Dependent ceases to be a Dependent under the terms of this Plan; or
  - the Employee parent becomes entitled to Medicare benefits (Part A, Part B, or both).
- with respect to a covered retired Employee and his or her Dependents:
  - the Employer files for Chapter 11 reorganization.

Note: If an Employee takes FMLA leave and does not return to work at the end of the leave, the Employee (and the Employee's Spouse and Dependent children, if any) will be entitled to elect COBRA if (1) they were covered under the Plan on the day before the FMLA leave began (or became covered during the FMLA leave); and (2) they will lose Plan coverage within 18 months because of the Employee's failure to return to work at the end of the leave. COBRA coverage elected in these circumstances will begin on the last day of the FMLA leave, with the same 18-month maximum coverage period (subject to extension or early termination) generally applicable to the COBRA qualifying events of termination or employment and reduction of hours.

Special COBRA rights apply to certain Employees and former Employees who are eligible for federal trade adjustment assistance (TAA) or alternative trade adjustment assistance (ATAA). These individuals are entitled to a second opportunity to elect COBRA for themselves and certain family members (if they did not already elect COBRA) during a special second election period. This special second election period lasts for 60 days or less. It is the 60-day period beginning on the first day of the month in which an eligible Employee or former Employee becomes eligible for TAA or ATAA, but only if the election is made within the six months immediately after the individual's group health plan coverage ended. **Contact the Plan Administrator promptly after qualifying for TAA or ATAA or the right to elect COBRA during a special second election period will be lost.**

3. Qualified Beneficiary

For purposes of this provision only, a Qualifying Beneficiary will mean any individual who, on the day before a Qualifying Event, is covered under this Plan as:

- an Employee;
- the Spouse of an Employee; or
- the Dependent child of an Employee.

A Qualified Beneficiary also includes a child born to, adopted by or placed for adoption with a covered Employee during the period of COBRA coverage. The Qualifying Event for such a child is the Qualifying Event that triggered the COBRA continuation coverage period during which the child is born, adopted or placed for adoption. If a second Qualifying Event occurs before the child is born, adopted or placed for adoption, then the second Qualifying Event also applies to the newborn, adopted child or child placed for adoption. If the Employee parent who is the Qualified Beneficiary has not elected COBRA continuation coverage, then any newborn, adopted child or child placed for adoption of that Employee who is born, adopted or placed for adoption after the Qualifying Event is not a Qualified Beneficiary.

A child of the covered Employee who is receiving benefits under the Plan pursuant to a Qualified Medical Child Support Order (QMCSO) received by the Employer during the covered Employee's period of employment with the Employer is entitled to the same rights to elect COBRA continuation coverage as an eligible Dependent child of the covered Employee.

4. Type of Benefits Offered

Qualified Beneficiaries may elect to continue any or all of the group health components in force on the day before the Qualifying Event occurs. Any changes in the benefits and/or the cost of coverage under this Plan will also apply to Qualified Beneficiaries who have continuation coverage under this provision.

COBRA coverage is the same coverage that the Plan gives to other participants under the Plan who are not receiving COBRA coverage. Each Qualified Beneficiary who elects COBRA will have the same rights under the Plan as other participants under the Plan, including annual open enrollment and special enrollment rights.

5. Maximum Duration of Coverage

When the Qualifying Event is the death of the Employee, the Employee's divorce or legal separation, or a Dependent child's losing eligibility as a Dependent child, COBRA continuation coverage lasts for up to a total of 36 months.

When coverage is lost due to termination of employment or reduction of hours worked, COBRA continuation coverage will be offered for a maximum of 18 months, except as follows:

- If another Qualifying Event occurs during the 18 months of COBRA coverage, continuation coverage for a Spouse or Dependent child can be extended for an additional 18 months, for a maximum of 36 months. The second Qualifying Event (death of the Employee, the Employee's divorce or legal separation, or a Dependent child's losing eligibility as a Dependent child) must be an event that would have caused the Spouse or Dependent child to lose coverage under the Plan had the first Qualifying Event not occurred.

  In the event of a second Qualifying Event, the Employee, Spouse or Dependent child must notify the Plan Administrator within 60 days after the later of:
  - the date of the second Qualifying Event; or
  - the date on which the Qualified Beneficiary would lose coverage under the terms of the Plan as a result of the second Qualifying Event (if it had occurred while the Qualified Beneficiary was still covered under the Plan).

  If the second Qualifying Event extension notice does not follow the procedures specified under Qualifying Event Notification Procedures and is not provided by this

due date, there will be no extension of COBRA continuation coverage due to a second Qualifying Event.

- If the Employee became entitled to Medicare benefits less than 18 months before the Qualifying Event, COBRA coverage for a Spouse or Dependent child who lose coverage as a result of the Qualifying Event can last until up to 36 months after the date of Medicare entitlement. For example, if a covered Employee becomes entitled to Medicare eight months before the date on which his employment terminates, COBRA continuation coverage for his Spouse and children who lost coverage as a result of his termination can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the Qualifying Event (36 months minus 8 months).

- If a Qualified Beneficiary has been determined to be disabled by the Social Security Administration at the time of a Qualifying Event, which is the termination of employment or reduction in hours, or at any time during the first 60 days of COBRA continuation coverage, coverage may be extended from 18 months to 29 months. Each Qualified Beneficiary will be entitled to the disability extension if one of them qualifies. Notice of such disablement must be given to the Plan Administrator prior to the conclusion of the 18 months of COBRA continuation coverage and within 60 days after the latest of:
  - the date of the Social Security Administration's disability determination;
  - the date of the Covered Employee's termination of employment or reduction of hours; and
  - the date on which the Qualified Beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the Covered Employee's termination of employment or reduction of hours.

  If the disability extension notice does not follow the procedures specified under Qualifying Event Notification Procedures and is not provided by this due date, there will be no disability extension of COBRA continuation coverage.

6. Qualifying Event Notification Procedures

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator has been notified that a Qualifying Event has occurred. When the Qualifying Event is the end of employment or reduction of hours of employment, or the death of the Employee, the Employer (if not the Plan Administrator) must notify the Plan Administrator of the Qualifying Event.

For the other Qualifying Events (divorce or legal separation of the Employee and Spouse or a Dependent child's losing eligibility for coverage as a Dependent child), the Employee, Spouse or Dependent child must notify the Plan Administrator within 60 days after the later of:

- the date of the Qualifying Event; or
- the date coverage is lost.

The notification must be provided in writing and mailed or hand-delivered to:

City of Hannibal and Board of Public Works
ATTN: Personnel Administrator
320 Broadway
Hannibal, MO. 63401

The written notice must be received by the above individual or, if mailed, postmarked no later than the last day of the required notice period. Oral communications and electronic (including e-mailed and faxed) notices are not acceptable. The notice must include all of the following:

- the name of the Plan;
- a description of the Qualifying Event;
- the date the Qualifying Event occurred;

- the names and address(es) of the covered Employee and all Qualified Beneficiaries;
- if the Qualifying Event is a divorce, the notice must include a copy of the divorce decree;
- in the event of a second Qualifying Event, the notice must include:
  -a description of the second Qualifying Event, and
  -the date of the second Qualifying Event;
- disability notification must include:
  -the name of the disabled Qualified Beneficiary,
  -the date when the Qualified Beneficiary became disabled,
  -the date the Social Security Administration made its determination, and
  -a copy of the Social Security disability determination.

If the notice does not follow the procedures specified above, and is not provided by the due date, the right to elect or extend COBRA continuation coverage will be lost.

7. COBRA Election Procedures

A Qualified Beneficiary may elect COBRA continuation coverage within the 60 day period beginning on the later of:

- the date coverage is lost under the Plan; or
- the date notification is made to the Qualified Beneficiary by the Plan Administrator or the duly authorized COBRA Administrator.

The COBRA election notice must be provided in writing and mailed or hand-delivered to:

City of Hannibal and Board of Public Works
ATTN: Personnel Administrator
320 Broadway
Hannibal, MO. 63401

The notice must be received by the above individual or, if mailed, postmarked no later than the last day of the required election notice period. Oral communications and electronic (including e-mailed and faxed) notices are not acceptable. **If the Employee, or his Spouse or a Dependent child does not submit a written election notice following these specified procedures and it is not provided by this due date, the right to elect COBRA continuation coverage will be lost.**

A Qualified Beneficiary who rejects his right to COBRA continuation coverage in writing can subsequently change his mind as long as the election notice is received by the due date. Coverage will be provided retroactively to the date of the Qualifying Event and premiums must be paid for the period of time from the Qualifying Event through the date of revocation.

Once the Plan Administrator receives notice that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the Qualified Beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage on behalf of their Spouses, and parents may elect COBRA continuation coverage on behalf of their children.

Qualified Beneficiaries who are entitled to elect COBRA may do so even if they have other group health plan coverage or are entitled to Medicare benefits on or before the date on which COBRA is elected.

8. Termination of COBRA Coverage

COBRA Continuation coverage will be terminated before the end of the maximum coverage period if:

- any required premium is not paid in full on time;

- after electing COBRA, the Qualified Beneficiary becomes covered under another group health plan which does not contain any enforceable exclusion or limitation with respect to a Pre-Existing Condition of such Qualified Beneficiary, unless such pre-existing exclusion or limitation does not apply to (or is satisfied by) the Qualified Beneficiary, taking into account prior creditable coverage as required by law;
- after electing COBRA, the Qualified Beneficiary becomes entitled to Medicare benefits (Part A, Part B or both);
- the Employer ceased to provide any group health plan for its Employees;
- during a disability extension period, the disabled Qualified Beneficiary is no longer considered disabled by the Social Security Administration.

The Plan Administrator must be notified within 30 days if, after electing COBRA, a Qualified Beneficiary becomes entitled to Medicare (Part A, Part B, or both) or becomes covered under other group health plan coverage. The Plan reserves the right to retroactively cancel COBRA continuation coverage and in that case will require reimbursement of all benefits paid after the date of Medicare entitlement or commencement of other group health plan coverage.

The Plan Administrator must be notified within 30 days after a disabled Qualified Beneficiary is determined to no longer be disabled. Coverage for all Qualified Beneficiaries will terminate as of the first day of the month that is more than 30 days after the Social Security Administration's determination that the Qualified Beneficiary is no longer disabled.

9. Cost of COBRA Continuation Coverage

Each Qualified Beneficiary is required to pay the entire cost of COBRA continuation coverage plus an administrative charge. The required payment for COBRA continuation coverage may not exceed 102% of the cost to the group health plan (including both Employer and Employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving COBRA continuation coverage. If coverage is extended to 29 months due to disability, the COBRA premium may be as much as 150% of the applicable premium for the 19th month through 29th month of continuation coverage.

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired Employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (eligible individuals). Under the new tax provisions, eligible individuals can take a tax credit equal to 65% of premiums paid for qualified health insurance, including COBRA continuation coverage. For questions about these new tax provisions, call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_index.asp.

10. Payment of COBRA Continuation Coverage

If COBRA continuation coverage is elected, payment is not required with the election form. However, the first payment must be made within 45 days after the date of the election (this is the date the election notice was post-marked, if mailed). This initial payment must cover the cost of COBRA coverage from the time coverage under the Plan would have otherwise have been terminated. It is the responsibility of the Qualified Beneficiary to make sure that the amount of the first payment is enough to cover this entire period. Contact the Plan Administrator to confirm the correct amount of the first payment.

If the first payment is not received in full within that 45-day period, all rights to COBRA continuation coverage under the Plan will be lost.

After making the first payment for COBRA continuation coverage, monthly payments are required for each subsequent month of COBRA continuation coverage. The amount due for each month for each Qualified Beneficiary will be disclosed in the election notice provided at the time of the Qualifying Event. Under the Plan, each of these monthly payments for COBRA continuation

coverage is due on the first day of the month for that month's COBRA continuation coverage. If monthly payments are made on or before the first day of the month to which it applies, the COBRA continuation coverage under the Plan will continue for that month without any break. The Plan will not send periodic notices of payments due for these coverage periods. Whether or not a notice is received, it is the Qualified Beneficiary's responsibility to pay the COBRA premiums on time. Although monthly premiums are due on the first day of each month, the Plan provides a grace period of 30 days to make each monthly payment. If premiums are not paid before the end of the grace period, the Plan reserves the right to retroactively cancel COBRA continuation coverage and in that case will require reimbursement of all benefits paid after the premium due date.

Failure to make a monthly payment before the end of the grace period for that month will result in loss of all rights to COBRA continuation coverage under the Plan.

11. **COBRA Continuation Coverage Questions**

Any questions about this Plan's COBRA continuation coverage should be addressed to:

City of Hannibal and Board of Public Works
ATTN: Personnel Administrator
320 Broadway
Hannibal, MO. 63401

For more information about COBRA rights, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Address and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

Note: Employees should keep the Plan Administrator informed of any change in addresses of family members in order to protect their family's rights. Employees should also keep a copy for their records of any notices they send to the Plan Administrator.

H. NO LOSS/NO GAIN PROVISION

If a person was covered by the prior version of this restated Plan, coverage will be neither gained nor lost solely because of the change to this restated Plan.

This provision applies to the annual deductible. Full credit is given for expenses incurred toward the deductible under the prior version of the Plan. Documentation is required. It is not the responsibility of the Plan Administrator to obtain prior documentation of the deductible.

SECTION V

DENTAL BENEFITS

A. OVERVIEW

The purpose of this section is to list and describe covered dental expenses and how much the Plan pays for each type of expense. In addition, expenses that are not covered under the Plan are listed. The Plan's liability is based on the provisions, limitations and exclusions described herein. Expenses submitted, including those not specifically addressed, are subject to the Plan Administrator's interpretation.

B. ONLY "USUAL, CUSTOMARY & REASONABLE" DENTAL EXPENSES ARE COVERED

This Plan pays only for eligible dental expenses that are Usual, Customary and Reasonable. Usual, Customary and Reasonable Charges are those which do not exceed what is accepted for a particular service by the majority of Dentists or dental care providers in an area.

C. DENTAL NECESSITY (DENTALLY NECESSARY)

All procedures, services or supplies must be required by, and appropriate for, Treatment of the Covered Person's dental condition according to broadly accepted standards of care as determined by the Plan.

D. ALTERNATE BENEFIT PROVISION

When more than one type of dental service could provide suitable Treatment based the Covered Person's current oral condition and in accordance with generally accepted profession standards of dental practice, the Plan will pay for the most cost effective Treatment plan. Expenses in excess of the amount determined by the Plan will not be considered a covered expense and therefore will be the patient's responsibility. A pre-determination of benefits should be obtained prior to starting Treatment for major dental work.

E. DENTAL CALENDAR YEAR DEDUCTIBLE

A deductible is the amount of covered expenses the Employee and Dependent(s) must incur during each year before the Plan will consider expenses for reimbursement. The individual deductible applies separately to each Covered Person. The family deductible applies collectively to all Covered Persons in the same family. When the family deductible is satisfied, no further deductible will be applied for any covered family member during the remainder of that year. The individual and family dental deductibles are shown in the Schedule of Dental Benefits.

F. DENTAL CALENDAR YEAR MAXIMUM

The maximum dental Calendar Year benefit this Plan will pay for each Covered Person is shown in the Schedule of Dental Benefits.

G. PRE-DETERMINATION OF BENEFITS

A pre-determination of benefits may be requested from the Claim Administrator by having the Dentist submit a claim form showing the necessary Treatment when the cost of Treatment is expected to be $300 or greater.

A notice of pre-determined benefits, based on benefits available at the time of preparation, will be sent to both the Dentist and the Covered Person. A pre-determination is an estimate only; it is not a guarantee of payment. Payment will be based on benefits available at the time charges are actually processed for payment.

H. DATE SERVICES ARE INCURRED

A charge shall be deemed incurred on the date the procedure or service is rendered or the supply is furnished, except that such charge shall be deemed incurred:

- with respect to crowns, bridges or cast restorations: on the date the tooth or teeth involved are prepared;
- with respect to any other Prosthetic Device: on the date the master impression is taken;
- with respect to root canal treatment: on the date the pulp chamber is opened;
- with respect to Orthodontic Treatment: on the date the Active Appliance is first placed.

I. LATE ENROLLEES

Late enrollees are eligible only for Diagnostic and Preventive Dental Expenses at the time of enrollment. Coverage for other dental expenses will be added as follows:

- Basic Dental Expense benefits will be provided after coverage has been in force for 6 months;
- Major Dental Expense benefits will be provided after coverage has been in force for 12 months;
- Orthodontic Treatment benefits will be provided after coverage has been in force 24 months.

J. DIAGNOSTIC AND PREVENTIVE DENTAL EXPENSES

The following diagnostic and preventive dental procedures are payable as shown in the Schedule of Dental Benefits:

- Oral examinations, limited to twice in any Calendar Year.
- Prophylaxis performed by a Dentist or Dental Hygienist, limited to twice in any Calendar Year.
- Fluoride treatments of a covered Dependent child if less than 14 years old, limited to twice in any Calendar Year.
- Diagnostic x-rays
  - Bitewings (limited to a maximum of 4 films) – limited to once per Calendar Year;
  - Intraoral periapical or occlusal (single films);
  - Extraoral superior or inferior maxillary film;
  - Full mouth series (at least 14 films, including bitewings if needed) – limited to once every five Calendar Years;
  - Panoramic film, maxilla and mandible, allowable only when necessary to diagnose accidental Injury, or in conjunction with cyst or tumor removal.
- Application of sealants to the unrestored permanent molars of a covered Dependent child if less than 16 years old, limited to one application every three Calendar Years.
- Space maintainers of a covered Dependent child if less than 16 years old, limited to initial Appliance only. Allowance includes all adjustments in the first six months after installation.
  - Fixed, unilateral, band or stainless steel crown type.
  - Removable, bilateral type.
- Emergency palliative treatment and other non-routine unscheduled visits, but only if no other services, except x-rays, are rendered during the visit.

K. BASIC DENTAL EXPENSES

The following basic dental expenses are payable as shown in the Schedule of Dental Benefits:

- Amalgam, silicate, acrylic, and composite fillings.
- Crowns, acrylic or plastic, without metal, and stainless steel.
- Diagnostic casts.
- Pin retention, exclusive of restorative material.
- Biopsy and examination of oral tissue.
- Extraction of teeth, including removal by surgery of impacted teeth.

- Endodontic services, including:
  - pulp capping;
  - remineralization;
  - vital pulpotomy;
  - apexification;
  - root canal therapy;
  - apicoectomy.
- Periodontal therapy, including:
  - periodontal root planing, limited to one treatment per area in any two Calendar Years;
  - occlusal adjustment, limited to a maximum of four quadrants in any one Calendar Year;
  - surgical services, limited to one treatment per area every three Calendar Years, including:
    -- gingivectomy, per tooth;
    -- osseous surgery, per quadrant;
    -- mucogingival surgery.
- Consultation with a Dentist other than the one providing treatment, limited to one consultation for each dental specialty in any Calendar Year.
- Oral surgery, including:
  - alveolectomy, per quadrant;
  - stomatoplasty with ridge extension, per arch;
  - removal of mandibular tori, per quadrant;
  - excision of hyperplastic tissue;
  - excision of pericoronal gingiva, per tooth;
  - removal of oalatal torus;
  - removal of cyst or tumor, not associated with removal of impacted teeth;
  - incision and drainage of abscess;
  - closure of oral fistula or maxillary sinus;
  - reimplantation of tooth;
  - frenectomy;
  - suture of soft tissue Injury;
  - sialolithotomy for removal of salivary calculus;
  - closure of salivary fistula;
  - dilation of salivary duct;
  - sequestrectomy for osteomyelitis or bone abscess, superficial;
  - maxillary sinusotomy for removal of tooth fragment or foreign body.
- Recementation of inlay, onlay, crown or bridge.
- Rebasing, limited to once per denture in any three Calendar Years.
- Relining, limited to once per denture in any one Calendar Year.
- Denture adjustments, limited to adjustments by a Dentist other than the one providing the denture, and adjustments are more than six months after the initial installation.
- Repair of dentures, crowns or bridgework.
- Tissue conditioning, limited to two treatments per arch in any Calendar Year.
- Adding teeth to partial dentures.
- General anesthesia in connection with surgical procedures only.
- Injectable antibiotics needed solely for treatment of a dental condition.

L. MAJOR DENTAL EXPENSES

The following major dental expenses are payable as shown in the Schedule of Dental Benefits:

- Cast restorations and crowns only when the tooth cannot be restored with a filling:
  - inlays;

- onlays, in the presence of an inlay;
- crowns and posts, acrylic with metal, porcelain, porcelain with metal and full cast metal (other than stainless steel).

- Fixed bridges.
- Bridge abutments.
- Bridge pontics, cast metal, sanitary, plastic or porcelain with metal and slotted pontic.
- Simple stress breakers, per unit.
- Dentures, including all adjustments done by the Dentist furnishing the denture in the first six months after installation. Temporary dentures older than one year are considered to be a permanent Appliance.
  - full dentures;
  - partial dentures.
- Implant, including the surgical insertion or removal.

Any benefits paid for temporary crowns, bridges, or dentures are subtracted from benefits paid for permanent crowns, bridges, or dentures. The total benefit paid for temporary dentures will not be more than the maximum benefit for permanent dentures.

M. ORTHODONTIA EXPENSES

Expenses are payable as outlined in the Schedule of Dental Benefits for an active course of Orthodontic Treatment for covered Dependent children who are less than 19 years of age. Covered services include:

- Necessary services related to an active course of Orthodontic Treatment, including but not limited to, tooth extractions, cephalometic x-rays and other required x-rays.
- Surgical exposure of impacted or unerupted teeth in connection with Orthodontic Treatment, including routine x-rays, local anesthetics and post-surgical care.
- Initial and subsequent, if any, installation of Active Appliance for an active course of Orthodontic Treatment.
- Adjustment of Active Appliances.
- Post-treatment stabilization.

Initial payment will be made when the Active Appliance is first placed. Further payments will be made on a periodic basis, as charges are submitted.

N. SERVICES COVERED BY BOTH MEDICAL AND DENTAL PLAN

This Dental Plan supplements the Employer's Medical Plan. When this Dental Plan and the Employer's Medical Plan provide benefits for the same charges, this Plan will subtract what the Employer's Medical Plan pays from what this Dental Plan would otherwise pay.

O. DENTAL EXPENSES NOT COVERED

Certain expenses are not allowable under dental coverage. Unless specifically stated elsewhere in this Plan, dental coverage does not apply to expenses resulting from any of these:

- Services furnished for Cosmetic reasons, including, but not limited to:
  - characterizing and personalizing Prosthetic Devices; and
  - making facings on Prosthetic Devices for any teeth in back of the second bicuspid.
- Dietary planning, plaque control, or oral hygiene instructions.
- Precision attachments.
- Treatment which does not meet accepted standards of dental practice.

- Experimental or Investigational Device, Treatment Methods, or Procedure as defined herein.
- Any Appliance or Prosthetic Device used to:
  - change vertical dimension;
  - restore or maintain occlusion, except to the extent that this Plan covers Orthodontic Treatment;
  - splint or stabilize teeth for periodontic reasons;
  - replace tooth structure lost as a result of abrasion or attrition; and
  - treat Temporomandibular Joint (TMJ) Syndrome.
- Replacement of a lost, stolen or missing Appliance or Prosthetic Device, or making a space Appliance or device.
- Any condition, disability or expense sustained as a result of being engaged in an activity primarily for wage, profit or gain, or that could entitle the Covered Person to a benefit under the Worker's Compensation Act or similar legislation.
- Services or supplies furnished by a person who ordinarily resides in the Covered Person's household or is related to the Covered Person, such as a spouse, parent, child, brother, sister, or in-law.
- Treatment for which no charge is made, such as:
  - treatment furnished by the Covered Person's employer, labor union, or similar group, in its dental or medical department or clinic;
  - a facility owned or run by any governmental body; and
  - any public program, except Medicaid, paid for or sponsored by any governmental body.

  However, the Plan will pay if a charge is made and the Plan is legally required to pay it.
- Replacement of an Appliance or Prosthetic Device, unless:
  - it is at least 10 years old and can't be made usable; or
  - it is damaged while in the Covered Person's mouth in an Injury.
- Charges incurred after coverage ends, except the Plan will pay for the following if all work is finished in the 31 days after coverage ends:
  - a crown, bridge or cast restoration, if the tooth is prepared before the coverage ends;
  - any other Prosthetic Device, if the master impression is made before the coverage ends; and
  - root canal treatment, if the pulp chamber is opened before the coverage ends.

  Orthodontic Treatment will only be paid to the end of the month in which the coverage ends, and the final payment will be pro-rated.
- Expenses for preparing itemized bills or benefit request forms.
- Expenses for broken appointments or telephone calls.
- Any or expense sustained as a result of being engaged in: an illegal or criminal occupation; commission or attempted commission of an assault or other illegal or criminal act; intentional or accidental atomic explosion or other release of nuclear energy, whether in peacetime or wartime; participation in a civil revolution or a riot; or a war or act of war which is declared or undeclared. However, any Injury which is otherwise covered by the Plan will not be denied if the Injury results from an act of domestic violence or a medical condition (including both physical and mental health conditions).
- Expenses which exceed the Usual, Customary and Reasonable Charge determined by the Plan.

SECTION VI

COORDINATION OF BENEFITS (C.O.B.) AND SUBROGATION

A. OVERVIEW

This coordination of benefits (COB) provision applies when a person has health care coverage under more than one plan. "Plan" is defined below.

The order of benefit determination rules below determine which plan will pay as the primary plan. The primary plan that pays first pays without regard to the possibility that another plan may cover some expenses. A secondary plan pays after the primary plan and may reduce the benefits it pays so that payments from all group plans do not exceed 100% of the total allowable expense.

B. DEFINITIONS

1. A "plan" is any of the following that provides benefits or services for medical or dental care or Treatment. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

   - "Plan" includes: group insurance, closed panel or other forms of group or group-type coverage (whether insured or uninsured); medical care components of group long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; No Fault Automobile Insurance (by whatever name it is called); and Medicare or other governmental benefits, as permitted by law.

   - "Plan" does not include: individual or family insurance; closed panel or other individual coverage (except for group-type coverage); Hospital indemnity insurance, school accident type coverage, benefits for non-medical components of group long-term care policies; Medicare supplement policies, Medicaid policies and coverage under other governmental plans, unless permitted by law.

     Each contract for coverage under the above is a separate plan. If a plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan.

2. The order of benefit determination rules determine whether this plan is a "primary plan" or "secondary plan" when compared to another plan covering the person.

   When this plan is primary, its benefits are determined before those of any other plan and without considering any other plan's benefits. When this plan is secondary, its benefits are determined after those of another plan and may be reduced because of the primary plan's benefits.

3. "Allowable expense" means a health care service or expense, including deductibles and copayments, that is covered at least in part by any of the plans covering the person. When a plan provides benefits in the form of services, (for example an HMO) the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the plans is not an allowable expense. The following are examples of expenses or services that are not allowable expenses:

   - If a person is covered by 2 or more plans that compute their benefit payments on the basis of Usual, Customary and Reasonable Charges, any amount in excess of the highest of the Usual, Customary and Reasonable Charges for a specific benefit is not an allowable expense.

   - If a person is covered by 2 or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.

   - If a person is covered by one plan that calculates its benefits or services on the basis of Usual, Customary and Reasonable Charges and another plan that provides its benefits or

services on the basis of negotiated fee, the primary plan's payment arrangements shall be the allowable expense for all plans.

- The amount a benefit is reduced by the primary plan because a Covered Person does not comply with the plan provisions. Examples of these provisions are pre-determination of benefits and Preferred Provider arrangements.

4. "Claim determination period" means a Calendar Year. However, it does not include any part of a year during which a person has no coverage under this plan, or before the date this COB provision or a similar provision takes effect.

5. "Closed panel plan" is a plan that provides health benefits to Covered Persons primarily in the form of services through a panel of providers that have contracted with or are employed by the plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

6. "Custodial parent" means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the Calendar Year without regard to any temporary visitation.

C. ORDER OF BENEFIT DETERMINATION RULES

When two or more plans pay benefits, the rules for determining the order of payment are as follows:

1. The primary plan pays or provides its benefits as if the secondary plan or plans did not exist.

2. A plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan Hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

3. A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is secondary to that other plan.

4. The first of the following rules that describes which plan pays its benefits before another plan is the rule to use.

   - Non-Dependent or Dependent. The plan that covers the person other than as a Dependent, for example as an Employee, member, subscriber or retiree is primary and the plan that covers the person as a Dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a Dependent; and primary to the plan covering the person as other than a Dependent (e.g. a Retired Employee); then the order of benefits between the two plans is reversed so that the plan covering the person as an Employee, member, subscriber or retiree is secondary and the other plan is primary.

   - Child Covered Under More Than One Plan. The order of benefits when a child is covered by more than one plan is:

     - The primary plan is the plan of the parent whose birthday is earlier in the year if:
       -- The parents are married;
       -- The parents are not separated (whether or not they ever have been married); or
       -- A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

       If both parents have the same birthday, the plan that covered either of the parents longer is primary.

       If the other plan does not have the birthday rule, the rule in the other plan will determine the primary plan.

- If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods or plan years commencing after the plan is given notice of the court decree.
- If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:
  -- The plan of the custodial parent;
  -- The plan of the Spouse of the custodial parent;
  -- The plan of the noncustodial parent; and then
  -- The plan of the Spouse of the noncustodial parent.

- Active or inactive Employee. The plan that covers a person as an Employee who is neither laid off nor retired, is primary. The same would hold true if a person is a Dependent of a person covered as a retiree and an Employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. Coverage provided an individual as a retired worker and a Dependent of an actively working Spouse will be determined under the rule labeled 4, Non-Dependent or Dependent.
- Continuation coverage. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another plan, the plan covering the person as an Employee, member, subscriber or retiree (or as that person's Dependent) is primary, and the continuation coverage is secondary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
- Longer or shorter length of coverage. The plan that covered the person as an Employee, member, subscriber or retiree longer is primary.

D. EFFECT ON THE BENEFITS OF THIS PLAN

When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a claim determination period are not more than 100 percent of total allowable expenses. The difference between the benefit payments that this Plan would have paid had it been the primary plan, and the benefit payments that it actually paid or provided shall be recorded as a benefit reserve for the Covered Person and used by this Plan to pay any allowable expenses, not otherwise paid during the claim determination period. As each claim is submitted, this Plan will:

- Determine its obligation to pay or provide benefits under its contract;
- Determine whether a benefit reserve has been recorded for the Covered Person; and
- Determine whether there are any unpaid allowable expenses during that claims determination period.

If there is a benefit reserve, the secondary plan will use the Covered Person's benefit reserve to pay up to 100% of total allowable expenses incurred during the claim determination period. At the end of the claims determination period, the benefit reserve returns to zero. A new benefit reserve must be created for each new claim determination period.

E. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. The Claim Administrator may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other plans covering the person claiming benefits. The Claim Administrator need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give the Claim Administrator any facts it needs to apply those rules and determine benefits payable. The Claim Administrator maintains physical, electronic and procedural safeguards that comply with federal law to guard nonpublic personal information.

F. FACILITY OF PAYMENT

A payment made under another plan may include an amount that should have been paid under this Plan. If it does, the Claim Administrator may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this Plan. The Claim Administrator will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

G. RIGHT OF RECOVERY

If the amount of the payments made by the Claim Administrator is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the Covered Person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

H. SUBROGATION, REIMBURSEMENT AND THIRD PARTY RECOVERY PROVISION

When this provision applies: If the Employee, Spouse, Dependent children, or anyone who receives benefits under this Plan becomes ill or is Injured and is entitled to receive money from any source, including but not limited to any party's liability insurance and uninsured/underinsured motorist proceeds, then the benefits provided or to be provided by the Plan are secondary, not primary, and will be paid only if the Covered Person fully cooperates with the terms and conditions of the Plan.

As a condition of receiving benefits under this Plan, the Employee or Covered Person agrees that acceptance of benefits is constructive notice of this provision in its entirety and agrees to reimburse the Plan 100% of the benefits provided without reduction for attorney's fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise. The person receiving benefits further agrees that any funds received by said person and/or their attorney, if any, from any source for any purpose shall be held in trust until such time as the obligation under this provision is fully satisfied. If the Employee or Covered Person retains an attorney, then the Employee or Covered Person agrees to only retain one who will not assert the Common Fund or Made-Whole Doctrines. Reimbursement shall be made immediately upon collection of any sum(s) recovered regardless of its legal, financial or other sufficiency. If the injured person is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative, shall be subject to this provision regardless of state law and/or whether the minor's representative has access or control of any recovery funds.

The Employee or Covered Person agrees to sign any documents requested by the Plan including but not limited to reimbursement and/or subrogation agreements as the Plan or its agent(s) may request. Also, the Employee or Covered Person agrees to furnish any other information as may be requested by the Plan or its agent(s). Failure or refusal to execute such agreements or furnish information does not preclude the Plan from exercising its right to subrogation or obtaining full reimbursement. Any settlement or recovery received shall first be deemed for reimbursement of medical expenses paid by the Plan. Any excess after 100% reimbursement of the Plan may be divided up between the Employee or Covered Person and their attorney if applicable. Any accident related claims made after satisfaction of this obligation shall be paid by the Employee or Covered Person and not the Plan.

The Employee or Covered Person agrees to take no action which in any way prejudices the rights of the Plan. If it becomes necessary for the Plan to enforce this provision by initiating any action against the Employee or Covered Person, then the Employee or Covered Person agrees to pay the Plan's attorney's fees and costs associated with the action regardless of the action's outcome.

The Plan Sponsor has sole discretion to interpret the terms of this provision in its entirety and reserves the right to make changes as it deems necessary.

If the Employee or Covered Person takes no action to recover money from any source, then the Employee or Covered Person agrees to allow the Plan to initiate its own direct action for reimbursement.

SECTION VII

CLAIM SUBMISSION PROCEDURES

A. HOW TO FILE A CLAIM

Submit all expenses to the address appearing on the Employee identification card. The ID card should be shown to providers each time services are received. If the provider submits the charge directly to the address on the ID card, it will aid in correct claims submission and timely claims processing.

A claim is considered to be filed when the Claim Administrator receives a billing which includes the following information:

- the Employee's name and social security number;
- the patient's name;
- a description of services or supplies provided, detailing the charge for each supply or service;
- the diagnosis;
- the date(s) of service;
- the provider's name and degree, address, telephone number, and tax identification number.

Upon receipt of this information, the claim will be deemed to be filed with the Plan. Additional information must also be provided to the Claim Administrator, although providing this information is not a requirement for the claim to be deemed to be filed. This additional information includes, but is not limited to:

- accident date and details;
- verification of Dependent eligibility;
- full-time student verification;
- coordination of benefit information, i.e., if another plan is the primary payer, a copy of their explanation of benefits (EOB);
- subrogation agreement.

Any initial claim payment or subsequent claim payment from an adjustment (e.g., PPO Network pricing, Medicare, payment error, etc.) will be considered part of the original claim.

B. WHEN TO FILE A CLAIM

A claim may be filed at any time after covered expenses have been incurred; however, a claim must be filed within one year of the occurrence in order to be eligible for payment. Claims filed later than that date may be declined or reduced unless it is not reasonably possible to submit the claim in that time.

C. HOW BENEFITS ARE PAID

The Plan Administrator must make a decision within a prescribed time period, as outlined below, after the claim is received. All submitted claims and appeals will fall into one of the three categories described below. The handling of the claim or later appeal will be governed, in all respects, by the appropriate category of the claim or appeal, and each time the claim or appeal is examined, a new determination will be made regarding the category into which the claim or appeal falls at that particular time.

Pre-Service Claims: Urgent

"Pre-Service Claim" is any claim for benefit under a group health plan with respect to which the terms of the plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining health care. In other words, if the **plan requires** pre-approval, then the claim is a "pre-service claim". Note: If the plan **does not require** pre-approval, requests/claims for advance information on the plan's possible coverage of treatment or supplies, or for advance approval of treatment or supplies do not qualify as "pre-service" and are not subject to the prescribed time period listed below.

"Urgent Care" is any claim for health care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Covered Person or the Covered Person's ability to regain maximum function, or, in the opinion of a physician with knowledge of the Covered Person's health condition, would subject the Covered Person to severe pain that cannot be adequately managed without the care or treatment at issue.

The Plan Administrator must notify the Covered Person of the benefit determination (adverse or favorable) as soon as possible, but not later than 72 hours after receipt. The initial notification will be provided by telephone, facsimile or other available similarly expeditious method, and the Plan will send the Covered Person written or electronic notification within three (3) days after the initial notice. No extensions are available on the prescribed timeframes in connection with Pre-Service Claims: Urgent.

If the claim is incomplete, the Plan Administrator will notify the Covered Person as soon as possible, but not later than 24 hours after the receipt, of the specific information necessary to complete the claim. The Covered Person will have 48 hours to provide the specified information necessary to complete the claim submission. The Plan's time limit for making a determination will be suspended from the time that it provides notice to the Covered Person of the incomplete claim until the date on which the Covered Person responds to the request for additional information. The Covered Person will be notified of the Plan's decision as soon as possible, but not later than 48 hours, after the earliest of (a) the Plan's receipt of the specified information, or (b) the expiration of the time given to the Covered Person to provide the specified information.

Pre-Service Claim: Non-Urgent

"Pre-Service Claim" is any claim for benefit under a group health plan with respect to which the terms of the plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining health care. In other words, if the **plan requires** pre-approval, then the claim is a "pre-service claim". Note: If the plan **does not require** pre-approval, requests/claims for advance information on the plan's possible coverage of treatment or supplies, or for advance approval of treatment or supplies do not qualify as "pre-service" and are not subject to the prescribed time period listed below.

"Non-Urgent Care" is any claim for health care or treatment with respect to which the application of the prescribed time periods outlined below would not jeopardize the life or health of the Covered Person or the Covered Person's ability to maintain maximum function.

The Plan Administrator must notify the Covered Person (in writing or electronically) of the benefit determination (adverse or favorable) as soon as possible, but not later than 15 days after receipt. The prescribed timeframe may be extended by the Plan for up to 15 days, provided that the Plan Administrator determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Covered Person, prior to the expiration of the initial 15 day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

If the claim is incomplete, the Plan Administrator will notify the Covered Person (in writing or electronically) as soon as possible, but not later than 5 days after receipt, of the specific information necessary to complete the claim. The Covered Person will have 45 days to provide the specified

information necessary to complete the claim submission. If the Covered Person fails to submit the missing information to complete the claim, the claim will be denied. The period for appealing the denied claim (denied because the Covered Person did not supply the missing information) will begin to run at the end of the 45 days within which the Covered Person was given to supply the missing information. The Plan's time limit for making a determination will be suspended from the time that it provides notice to the Covered Person of the incomplete claim until the date on which the Covered Person submits the missing information. Upon receipt of the specified information the Covered Person will be notified of the Plan's decision as soon as possible, but not later than 15 days after receipt.

Concurrent Claims

"Concurrent Care" is any claim where decisions arise when a plan has approved an on-going course of treatment to be provided over a period of time or number of treatments, and include a plan's extension, reduction or termination of the course of treatment or number of treatments.

If the Plan **does not require** the Covered Person to obtain approval of a health service **prior** to getting treatment, then there is no need to contact the Plan Administrator to request an extension of a course of treatment. The Covered Person simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-Service Claim.

If the Plan Administrator is notifying the Covered Person of a reduction or termination of a course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments, the Covered Person will be notified sufficiently in advance of the reduction or termination to allow the Covered Person to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.

If the Plan Administrator receives a request from a Covered Person to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care, the Plan Administrator will decide as soon as possible, but not later than 24 hours after receipt of the claim, as long as the Covered Person makes the request at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

If the Covered Person submits the request with less than 24 hours prior to the expiration of the prescribed period of time or number of treatments, the request will be treated as a claim involving urgent care and decided within the pre-service urgent care timeframe stated above.

If the request from the Covered Person does not involve urgent care, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (either as a pre-service non-urgent claim or a post-service claim).

Post-Service Claims

"Post-Service Claim" is any claim for benefit that **does not require** pre-approval prior to obtaining health services and payment is being requested for health care already rendered to the Covered Person.

The Plan Administrator must notify the Covered Person (in writing or electronically) of the benefit determination as soon as possible, but not later than 30 days after receipt. The prescribed timeframe may be extended by the Plan for up to 15 days, provided that the Plan Administrator determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Covered Person, prior to expiration of the initial 30 day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

If the claim is incomplete the Plan Administrator will notify the Covered Person (in writing or electronically) as soon as possible, but not later than 30 days after receipt, of the specific information necessary to complete the claim. The Covered Person will have 45 days to provide the specified information necessary to complete the claim submission. If the Covered Person fails to submit the missing information to complete the claim, the claim will be denied. The period for appealing the denied claim (denied because the Covered Person did not supply the missing information) will begin to run at the end of the 45 days within which the Covered Person was given to supply the missing

information. The Plan's time limit for making a determination will be suspended from the time that it provides notice to the Covered Person of the incomplete claim until the date on which the Covered Person submits the missing information. Upon receipt of the specified information the Covered Person will be notified of the Plan's decision as soon as possible, but not later than 15 days after receipt.

Payment of Plan benefits is made directly to the Covered Person unless a request is made in writing that payment be made to the Hospital or other provider of service.

If the claim is denied, in whole or in part, the Plan Administrator will notify the Covered Person in writing or electronically (telephone or facsimile or similar method of notification followed by written notification in case of urgent care claims) why the claim was denied, and the Plan Administrator will provide additional information that will help the Covered Person pursue the Covered Person's right to appeal the adverse determination. If the Covered Person chooses to appeal the Plan's adverse benefit determination, the appeal will be governed by rules that assure the Covered Person a "full and fair" review.

If the Covered Person is denied benefits based upon the Plan's finding that the Covered Person is/was ineligible for benefits, the denial of benefits gives the Covered Person the opportunity to appeal the Plan's decision.

D. APPEAL PROCEDURE

In cases where a claim for benefits is denied, in whole or in part, and the Covered Person believes the claim has been denied wrongly, the Covered Person may appeal the denial and review pertinent documents. The claims procedures of this Plan provide a Covered Person with a reasonable opportunity for a "full and fair review" of the claim and adverse benefit determination, including the right, if necessary, to file two separate appeals.

A Covered Person has 180 days following receipt of a notification of an adverse benefit determination to file an appeal. An oral request for review is acceptable for urgent care claims and may be made by calling the number on the Employee Identification Card or the Explanation of Benefits and asking the Plan to register the oral appeal. Requests for appeals should be sent to:

RightCHOICE Benefit Administrators
Attn: Appeals Department
P.O. Box 8562
St. Louis, MO 63127

When the Covered Person appeals an adverse determination, the Plan will provide a "full and fair review" which will include the following features:

- The Covered Person will have the opportunity to submit written comments, documents, records, and other information related to the claim.
- At the Covered Person's request (and free of charge), the Covered Person will be provided with reasonable access to (and copies of) all documents, records, and other information relevant to the claim for benefits. Included in this category are any documents, records or other information in the Covered Person's claim file, whether or not those materials were relied upon by the Plan in making its adverse determination. The Covered Person also have the right to review documentation showing that the Plan followed its own internal processes for ensuring appropriate decision making.
- The review of the claim will take into account all comments, documents, records, and other information submitted by the Covered Person relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.
- Any appeal of an adverse determination will not afford deference to the initial adverse determination, and the review will be conducted by a designated Plan representative who did not make the original determination and does not report to the Plan representative who made the original determination.

- In deciding an appeal of any adverse benefit determination that is based on a medical/dental judgment Experimental or Investigational, or not medically necessary or appropriate, the Plan will consult with a health care professional who has appropriate training and experience in the particular field of medicine involved in the medical/dental judgment. This health care professional will not be the same professional who was originally consulted in connection with the adverse determination; neither will this health care professional report to the health care professional who was consulted in connection with the adverse determination.
- The Plan will identify medical/dental or vocational experts whose advice was obtained on behalf of the Plan in connection with an adverse benefit determination of the claim, whether or not that advice was relied upon in making the benefit determination.

After the Covered Person submits the claim for appeal, the Plan must make a decision on the claim within a short period of time as shown below for the various types of claims.

Pre-Service Claims: Urgent

The Plan Administrator must notify the Covered Person of the benefit determination as soon as possible, but no later than 36 hours after the Plan receives the request for review of the prior benefit determination. All necessary information, including the Plan's benefit determination on review, will be transmitted between the Plan and the Covered Person by telephone, facsimile, or other available similarly expeditious method.

Pre-Service Claims: Non-Urgent

The Plan Administrator must notify the Covered Person (in writing or electronically) of the benefit determination as soon as possible, but not later than 15 days after the Plan receives the request for review of the prior benefit determination.

Concurrent Claims

Response time depends on type of claim. The Plan Administrator will determine the applicable category and apply the corresponding timeframes indicated.

Post-Service Claims

The Plan-Administrator must notify the Covered Person (in writing or electronically) of the benefit determination as soon as possible, but not later than 30 days after the Plan receives the request for review of the prior benefit determination.

If, for any reason, the Covered Person does not receive a written response within the time periods mentioned above, the Covered Person may assume that the appeal has been denied. Upon expiration of that time period without receipt of a written decision or upon receipt of notice of the Plan’s adverse decision regarding the appeal, the Covered Person has 180 days to file, in writing, a second appeal of the adverse determination.

IF THE FIRST APPEAL IS DENIED

If the first appeal of the claim is denied, the Plan will send the Covered Person written or electronic notification that will tell the Covered Person why the appealed claim was denied. The Plan will provide additional information that will help the Covered Person pursue his right to the second appeal of the adverse determination. An adverse benefit determination also includes a denial of benefits based on a finding that the Covered Person was ineligible for benefits at the time; such adverse benefit determination of the Covered Person's eligibility will allow the Covered Person the opportunity to appeal the Plan's decision.

FINAL APPEAL

If the Covered Person is dissatisfied with the outcome of the first appeal, the Covered Person may request a second appeal review. To initiate a second appeal review, the Covered Person should follow the same process required for the first appeal. The Covered Person must submit a request for a final appeal within 180 days of receipt of the notice denying his first appeal.

The Plan Administrator shall notify the Covered Person of the Plan's benefit determination on review within a reasonable period of time. Timeframes for benefit determination are identical to those listed for the first appeal.

The individual who decides the second appeal will not be the same individual who decided the initial claim denial or the first appeal and will not be the subordinate of such individuals. The Plan Administrator may secure independent medical/dental or other advice and require such other evidence as it deems necessary to decide the second appeal, except that any medical/dental expert consulted in connection with the appeal will be different from any expert consulted in connection with the initial claim or the first appeal. (The identity of a medical/dental expert consulted in connection with the appeal will be provided.) If the claim on appeal is denied in whole or in part for a second time, the Covered Person will be furnished with a notice of adverse benefit determination. The notice shall include the same information that was included in the first adverse determination letter.

If, for any reason, the Covered Person does not receive a written response to the second appeal within the time periods set forth above, the Covered Person may assume that the second appeal has been denied.

The decision by the Plan Administrator or other appropriate named fiduciary of the plan on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. All claim review procedures provided for in the plan must be exhausted before any legal action is brought. Any legal action for the recovery of any benefits must be commenced within one year after the plan's claim review procedures have been exhausted.

SECTION VIII

ERISA

A. NAMED FIDUCIARIES

The following persons shall be named fiduciaries of the Plan, pursuant to ERISA. Any such person or group of persons may serve in more than one (1) fiduciary capacity with respect to the Plan. Each individual named fiduciary under the Plan shall be allocated the responsibility(ies) specified below and shall have discretionary authority to take such actions as are necessary to fulfill such responsibility(ies). Any named fiduciary may employ one (1) or more persons to render advice with respect to any responsibility(ies) allocated to such named fiduciary under the Plan. Any named fiduciary may designate in writing a person other than a named fiduciary to carry out all or a portion of such named fiduciary's allocated fiduciary responsibility(ies) as set forth in a written instrument executed by the named fiduciary, the designated person, and the Employer. No named fiduciary shall be liable with respect to a breach of fiduciary duty, if such breach was committed before he became a named fiduciary or after he ceases to be a named fiduciary.

The Plan Administrator shall be named fiduciary for all purposes of the Plan. The Plan Administrator shall have the sole discretionary authority to:

- amend and/or terminate the Plan in accordance with the "Amendment or Termination" provision as described herein;
- make such changes as it deems prudent from time to time in the funding policy of the Plan;
- make such rules as may be necessary for administration of the Plan, construe the Plan subject to its provisions, supply any omissions and reconcile any inconsistencies, make equitable adjustments for any mistakes or errors and decide all questions arising in the interpretation of the Plan based on information available when the review was made; all of which shall be conclusive and binding on all parties;
- formulate the claims procedures of the Plan;
- discharge its duties with respect to the Plan:
  - solely in the interest of the participant and their Dependents;
  - for the exclusive purpose of providing benefits to participants and their Dependents and of defraying reasonable expenses of administering the Plan; and
  - with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and like aims.

Further, the Plan Administrator -

- shall be entitled to rely on information and material furnished by any third party retained by the Employer and upon all options given by legal counsel employed by them.
- shall be fully protected in respect of any action taken or suffered by them in good faith and in reliance upon any such third party or counsel, and all action so taken or suffered shall be conclusive upon all participants and Dependents under the Plan.
- shall provide a full, fair and final review of any claim denied by the Plan or by the Claim Administrator, if any, retained by the Employer in accordance with the Plan's claims procedures.

The Employer shall serve as Administrator of the Plan for purposes of ERISA. As Administrator, the Employer shall perform the following duties:

- comply with the requirements of ERISA with respect to the Plan Description, Summary Plan Description, Summary Annual Report and other reports to be provided to the Secretary of Labor and/or Participants;

- establish, prepare and maintain all records required for completion of reports to participants and to governmental agencies;
- retain, at its option, a Claim Administrator to be responsible for all or any portion of the day-to-day administration of the Plan, within the provisions, interpretations and rules made by the Employer and stated herein, including determination of claims;
- retain, at its option, an Actuarial or Benefit Plan Consultant to be responsible for all or any portion of the day-to-day administration of the Plan, actuarial evaluation, and necessary funding.

Such Claim Administrator shall perform the duties specified in any separate Administrative Services Agreement entered into between the Claim Administrator and the Employer, the terms and provisions of which shall be incorporated herein by reference to the same extent as if herein written. Likewise, such Actuarial or Benefit Plan Consultant shall perform the duties specified in any separate Consultative Service Agreement entered into between the Actuarial or Benefit Plan Consultant and the Employer, the terms and provisions of which shall be incorporated herein by reference to the same extent as if herein written.

B. FUNDING POLICY AND BASIS OF PAYMENTS TO AND FROM PLAN

Both the Employee, through payroll deductions, and the Employer contribute to the cost of the Plan. With respect to such contributions, the Employer acts as trustee and uses such contributions for the exclusive purpose of providing benefits to participants and their beneficiaries.

C. AMENDMENT OR TERMINATION OF PLAN

Although it is their intent that the Plan remain in effect indefinitely, the Plan may, at any time, be amended, suspended or discontinued in whole or in part by the Employer. This includes amending the benefits under the Plan or the Trust Agreement (if any).

D. TRUST AGREEMENT AND COLLECTIVE BARGAINING AGREEMENT

If this Plan is established under either a Trust Agreement or a Collective Bargaining Agreement, that Agreement is made a part of the Plan. A copy of the appropriate Agreement is available for examination by Employees and their Dependents at the office of the Plan Administrator during normal business hours. Also, upon written request, the following items will be furnished to an Employee or Dependent:

- a copy of the Trust Agreement or Collective Bargaining Agreement, as the case may be;
- a complete list of Employers and Employee organizations sponsoring the Plan;
- information as to whether a particular Employer or Employee organization is a sponsor of the Plan. If the Employer is a sponsor, then the address must be supplied.

E. CERTAIN EMPLOYEE RIGHTS UNDER ERISA

As a participant in this Plan a person is entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

1. Receive Information About the Plan and Benefits

Examine, without charge, at the Plan Administrator's office, and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) filed by the Plan with the U. S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

2. Continue Group Health Plan Coverage

Continue health care coverage for Employee, Spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. The Employee or his Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under this group health Plan, if participant had creditable coverage from another plan. The participant should be provided a certificate of creditable coverage, free of charge, from the participant's group health plan or health insurance issuer when the participant loses coverage under the plan, when the participant becomes entitled to elect COBRA continuation coverage, when the participant's COBRA continuation coverage ceases, if the participant requests it before losing coverage, or if the participant requests it up to 24 months after losing coverage. Without evidence of creditable coverage, a participant may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after his enrollment date in his coverage.

3. Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Employee benefit Plan. The people who operate this Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the participant and other Plan participants and beneficiaries. No one, including the participant's Employer, his union, or any other person, may fire a participant or otherwise discriminate against him in any way to prevent him from obtaining a welfare benefits or exercising his rights under ERISA.

4. Enforce a Participant's Rights

If a participant's claim for a welfare benefit is denied or ignored, in whole or in part, the participant has a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps that a participant can take to enforce the above rights. For instance, if a participant requests a copy of plan documents or the latest annual report from the Plan and does not receive them within 30 days, he may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and to pay the participant up to $110 a day until he receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If a participant has a claim for benefits which is denied or ignored, in whole or in part, he may file suit in a state or Federal court. In addition, if the participant disagrees with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, he may file suit in Federal court. If it should happen that the Plan fiduciaries misuse the Plan's money, or if a participant is discriminated against for asserting his rights, the participant may seek assistance from the U. S. Department of Labor, or he may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If the participant is successful, the court may order the person he has sued to pay these costs and fees. If the participant loses, the court may order him to pay these costs and fees, for example, if it finds his claim is frivolous.

5. Assistance With Participant Questions

If a participant has any questions about this Plan, he should contact the Plan Administrator. If a participant has any questions about this statement or about his rights under ERISA, or if he needs assistance in obtaining documents from the Plan Administrator, he should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in his telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W.,

Washington, D.C. 20210. A participant may also obtain certain publications about his rights and responsibilities from ERISA by calling the publications hotline of the Employee Benefits Security Administration.

SECTION IX

GENERAL PROVISIONS

A. GENDER AND NUMBER

When used in this Plan, the masculine includes the feminine, the singular the plural and the plural the singular.

B. PLAN

This Plan Document describes the Comprehensive Dental Benefits and the provisions for reimbursing claims submitted from eligible Covered Persons.

C. ADMINISTRATOR

As defined by Federal Law, means:

- the Employer in the case of an Employee benefit plan established or maintained by a single Employer;
- the Employee organization in the case of a plan established or maintained by an Employee organization; or
- in the case of a plan established or maintained by two or more Employers or jointly by one or more Employers and one or more Employee organizations, the Association, committee, joint Board of Trustees, or other similar group of representatives of the parties who established or maintained the plan.

D. CLAIM ADMINISTRATOR

Means The RightCHOICE Benefit Administrators employed by the Employer, and responsible for the processing of claims and payments of benefits, administration, accounting, reporting and/or other services contracted for by the Administrator.

E. PHYSICAL EXAMINATION AND AUTOPSY

The Employer shall have the right and opportunity to examine the person with respect to whom benefits are claimed when and so often as they may reasonably require during pendency of claim hereunder, and also the right and opportunity to make an autopsy in case of death where it is not forbidden by law.

F. LEGAL ACTIONS

No action at law or in equity shall be brought to recover under the Plan prior to the expiration of sixty (60) days after proof of claim has been filed in accordance with the requirements of the Plan and the Plan's claims procedures, nor shall such action be brought at all unless brought within three (3) years from the expiration of the time within which such proof of claim is required in accordance with the Plan's claims procedures.

G. NOT WORKERS' COMPENSATION INSURANCE

The coverage provided by the Plan is not in lieu of and does not affect any requirements of coverage by Workers' Compensation Insurance.

H. ASSIGNMENT OF BENEFITS AND CLAIMS OF CREDITORS

The Covered Person may assign the benefits under this Plan only to such place or person rendering services or furnishing supplies for which benefits are payable. However, if those benefits are paid directly to the Employee, the Plan shall be deemed to have fulfilled its obligations with respect to such benefits. The Plan Administrator shall not be responsible for the validity of any such assignment. Any payment made according to such assignment and in good faith by the Plan Administrator will discharge the Plan Administrator to the extent of any such payment. Payment of benefits which have been assigned will be made directly to the assignee unless a written request not to honor the assignment, signed by the covered Employee and the assignee, has been received before the proof of loss is submitted.

SECTION X

HIPAA PRIVACY AND SECURITY REQUIREMENTS

A. HIPAA SECURITY RULE

This provision is intended to bring the Plan into compliance with the requirements of 45 C.F.R § 164.314(b)(1) and (2) of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, 45 C.F.R. parts 160, 162, and 164 (the regulations are referred to herein as the "HIPAA Security Standards") by establishing the Plan Sponsor's obligations with respect to the security of Electronic Protected Health Information. The obligations set forth below are effective on April 21, 2006.

1. Definitions

For purposes of this provision, the following terms have these meanings:

a. **Electronic Protected Health Information** – "Electronic Protected Health Information" has the meaning set forth in 45 C.F.R. §160.103, as amended from time to time, and generally means protected health information that is transmitted or maintained in any electronic media.

b. **Security Incidents** – "Security Incidents" has the meaning set forth in 45 C.F.R. § 164.304, as amended from time to time, and generally means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system.

2. Plan Sponsor Obligations

Where Electronic Protected Health Information will be created, received, maintained, or transmitted to or by the Plan Sponsor on behalf of the Plan, the Plan Sponsor will reasonably safeguard the Electronic Protected Health Information as follows:

a. Plan Sponsor will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that Plan sponsor creates, receives, maintains, or transmits on behalf of the Plan;

b. Plan Sponsor will ensure that the adequate separation that is required by 45 C.F.R. § 164.504(f)(2)(iii) of the HIPAA Privacy Rule is supported by reasonable and appropriate security measures;

c. Plan Sponsor will ensure that any agent, including a subcontractor, to whom it provides Electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect such Information; and

d. Plan Sponsor will report to the Plan any Security Incidents of which it becomes aware as described below:

   i. Plan Sponsor will report to the Plan within a reasonable time after Plan Sponsor becomes aware, any Security Incident that results in unauthorized access, use, disclosure, modification, or destruction of the Plan's Electronic Protected Health Information; and

   ii. Plan Sponsor will report to the Plan any other Security Incident on an aggregate basis every quarter, or more frequently upon the Plan's request.

DEFINITIONS

The following terms define specific wording used in this Plan. These definitions should not be interpreted to extend coverage unless specifically provided for under Covered Dental Expenses.

Active Appliance

An Appliance like braces used in Orthodontic Treatment to move teeth.

Active Employee

An Employee who performs all of the duties of his job with the Employer on a full-time basis. This job may be performed either at the Employer's normal place of employment or at some other place to which the regular business operations of the Employer require that person to go.

To be "full-time," an Active Employee must be scheduled to work for the Employer at least 29 hours per week and on the regular payroll of the Employer for that work.

Adopted Children

A child is considered to be adopted only when adopted or placed for adoption and only if the adoption or placement happens before the child's 18th birthday. When an Employee assumes and retains a legal obligation for total or partial support of a child in anticipation of adopting the child that is considered placement for adoption. The child's placement terminates when that legal obligation is no longer in effect.

Amendment

A formal document signed by the representative of City of Hannibal and the Board of Public Works. The Amendment changes the provisions of the Plan and applies to all Covered Persons, including those persons covered before the Amendment becomes effective, unless otherwise specified.

Annual Open Enrollment Period

The specified period of time designated by the Plan Administrator, and communicated to eligible Employees, during which eligible Employees and Dependents who failed to enroll in a timely manner may enroll for coverage in this Plan as late enrollees.

Appliance

Any dental device other than a Prosthetic Device.

Calendar Year

January 1st through December 31st of the same year.

COBRA

Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Cosmetic Surgery or Procedure

Any surgery, treatment or procedure performed or supply provided primarily to:

- improve physical appearance or to change or restore bodily form without materially correcting a bodily malfunction, condition or disease; or
- prevent or treat a mental or nervous disorder through a change in bodily form.

Covered Employer

City of Hannibal and Board of Public Works

Covered Person

An Employee, Retiree or Dependent who is covered under this Plan.

Dental Hygienist

A person who is licensed to perform specified dental procedures under the law of the jurisdiction in which the dental procedure is performed and operating within the scope of his or her license.

Dentally Necessary (Dental Necessity)

A dental treatment, procedure or supply which a qualified party or entity selected by the Plan determines is:

- provided for the diagnosis or direct treatment of a dental injury, condition or disease;
- appropriate and consistent with the symptoms and findings or diagnosis and treatment of the Covered Person's dental injury, condition or disease; and
- provided in accordance with generally accepted professional standards of dental practice.

The fact that the Covered Person's Dentist orders, prescribes or renders treatments, procedures or supplies does not automatically mean such treatments, procedures or supplies are Dentally Necessary.

Dentist

A person who is properly trained and licensed by the applicable state law in which he practices dentistry and holds the degree of Doctor of Dental Surgery, (D.D.S) or Doctor of Dental Medicine (D.M.D.).

Dependent

Eligible Dependents include:

- An Employee's Spouse.
- An Employee's unmarried children, from birth up to the last day of the Calendar Year in which the child attains age 19, including natural children and Adopted Children. Children also includes Foster Children and stepchildren who are primarily dependent upon the Employee for support and maintenance.
    - If a Dependent is a Full-Time Student as determined by the Plan, unmarried and primarily dependent upon the Employee for support and maintenance, coverage will be extended up to the last day of the Calendar Year in which the child attains age 24. Proof of a Dependent's status as a Full-Time Student must be furnished to the Employer from time to time as may reasonably be requested. Proof must be acceptable to the Employer. Coverage will continue through the summer vacation period provided the Dependent is enrolled as a Full-Time Student for the fall semester (documentation will be required). If the Dependent does not actually return to school for the fall semester, coverage will terminate on the first day of the fall semester. Otherwise, coverage will continue to the end of the month when a Dependent ceases to be a Full-Time Student.
    - Coverage will also be extended for unmarried Dependent children, regardless of age, who are Physically or Mentally Handicapped, classified as disabled before the limiting age and primarily dependent on the Employee for support and maintenance. To continue coverage for a handicapped child, proof of the handicap and dependency must be furnished to the Employer within 31 days after the last day of the Calendar Year in which the Dependent attains age 19 (or 24, if a Full-Time Student), and from time to time as may reasonably be requested. Proof must be acceptable to the Employer.

  "Dependent on the Employee for support and maintenance" means the Employee has a legal right to claim such child as a Dependent on his federal income tax form.
- Children the Employee must cover under a Qualified Medical Child Support Order (QMCSO). A copy of the Plan's procedures governing QMCSO determinations may be obtained from the Employer at no cost.

These persons are excluded as Dependents:

- the legally separated or divorced former Spouse of the Employee;

- any person who is on active duty in any military service of any country; or

if a husband and wife are both Active Employees as defined by the Plan, they may elect to maintain separate coverage, or one may cover the other as a Dependent. However, an Employee cannot be covered as both an Employee and a Dependent.

If husband and wife are both covered as Employees under the Plan, their children will be covered as Dependents of the husband or the wife, but not both.

If a person covered under this Plan changes status from Employee to Dependent or Dependent to Employee, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for all amounts applied to maximums.

Employee

Any person who is deemed to be that of a common law employee by the Employer (without regard to any classification by any other person or entity, including but not limited to the Internal Revenue Service, a court of competent jurisdiction, an arbitrator, or any federal, state or local government or agency or subdivision thereof) and who is regularly scheduled to work 29 hours or more per week. The term "Employee" does not include any "leased employees", independent contractor or any employees who are part-time or temporary or who normally work less than 29 hours a week for the Employer.

Employer

City of Hannibal and Board of Public Works

ERISA

The Employee Retirement Income Security Act of 1974, as amended.

Experimental or Investigational Device, Treatment or Procedure

A device, treatment or procedure is experimental or investigative when the Plan determines it:

- is not in general use in the practice of dentistry;
- is under continued scientific testing or ongoing clinical trials;
- does not have a measurable benefit for a dental injury, condition or disease; or
- has not been proven to be safe and effective.

In making a determination, the Plan will rely on outside sources including, but not limited to, dental consultants, dental journals or governmental regulations.

Foster Child

A child who is related to the Employee by blood or marriage or a child for whom the Employee has assumed a legal obligation when all of the following are met:

- such child normally lives with the Employee in a parent-child relationship, and
- the Employee has a legal right to claim such child as a Dependent on his federal income tax form.

A foster child is not a child:

- temporarily living with the Employee;
- placed with Employee by a social service agency which retains control of the child; or
- whose natural parent may exercise or share parental responsibility or control.

Full-Time Student

A person who is attending classes at an accredited school with a regular teaching staff, curriculum and student body. Attendance must be full-time, which is the number of credits or hours required by the school to be considered a Full-Time Student.

Injury

All damage to a Covered Person's mouth due to an accident, and all complications rising from that damage. But the term Injury does not include damage to teeth, Appliances or Prosthetic Devices which results from chewing or biting food or other substances.

Lifetime

The period of time the Employee and/or Dependents participate in this Plan or any other plan sponsored by the Employer. Under no circumstances does Lifetime mean during the lifetime of a Covered Person.

Medicare

Title XVIII (Health Insurance for the aged) of the United States Social Security Act as amended.

No Fault Automobile Insurance

The basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

Orthodontic Treatment

The movement of one or more teeth by the use of Active Appliances, including:

- diagnostic services;
- the treatment plan;
- the fitting, making and placement of an Active Appliance; and
- all related office visits, including post-treatment stabilization.

Physically or Mentally Handicapped

The inability of a person to be self-sufficient as the result of a condition such as mental retardation, cerebral palsy, epilepsy or another neurological disorder and diagnosed by a Physician as a permanent and continuing condition.

Physician

A person acting within the scope of his/her license and holding the degree of Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), or Doctor of Dental Medicine (D.M.D.) and who is legally entitled to practice medicine in all its branches under the laws of the state or jurisdiction where the services are rendered.

Plan Administrator

The Plan Administrator, who is the sole fiduciary of the Plan, has all discretionary authority and control over the operation and administration of the Plan. The Plan Administration may choose to hire a consultant and/or contract administrator to perform specified duties in relation to the Plan. The Plan Administrator also has the right to amend, modify or terminate the Plan at any time or in any manner.

Prosthetic Device
A device which is used to replace missing or lost teeth or tooth structure, including all types of dentures, crowns, bridges, pontics and cast restorations.

Qualified Medical Child Support Order (QMCSO)

A medical child support order (any judgement, decree or order issued by a court of competent jurisdiction or issued through an administrative process established under State law and having the force and effect of law under applicable State law that provides for child support) that creates or recognizes the right of an alternate recipient (Plan participant's child) to receive benefits for which a participant is eligible under the Plan. To be a "qualified" order, the following information must be included:

- the name and last known mailing address of the Plan participant and each alternate recipient;

- a reasonable description of the type of coverage to be provided by the Plan to each alternate recipient; or the manner in which the type of coverage is to be determined; and
- the period to which the order applies.

Retired Employee

A former Active Employee of the Covered Employer who was retired while employed by the Covered Employer under the formal written retirement Plan of the Covered Employer and elects to contribute to the plan the contribution required from the Retired Employee.

Spouse

The person recognized as the covered Employee's husband or wife under the laws of the state where the covered Employee lives.

Temporomandibular Joint (TMJ) Syndrome

Any misalignment, dysfunction or other disorder of the jaw joint (or of the complex of muscles, nerves and tissues related to that joint). It includes temporomandibular joint dysfunction, arthritis or arthrosis, other craniomandibular joint disorders, and myofacial or orofacial pain syndrome. It does not include a fracture or dislocation which results from an injury, any misalignment, dysfunction or other disorder of the jaw joint (or of the complex of muscles, nerves and tissues related to that joint).

Usual, Customary and Reasonable Charge

A charge which is not higher than the usual charge made by the provider of the care or supply and does not exceed the usual charge made by most providers of like service in the same area. This test will consider the nature and severity of the condition being treated. It will also consider medical complications or unusual circumstances that require more time, skill or experience.

Waiting Period

The period of time that must pass under this Plan before an Employee or Dependent is eligible to enroll in the Plan (or other health plan as the case may be). Notwithstanding the foregoing, if an Employee or Dependent enrolls as a Late Enrollee, or Special Enrollee on the special enrollment date, any period before such late or special enrollment is not a Waiting Period.

ERISA INFORMATION

PLAN NAME:	City of Hannibal and Board of Public Works Dental Benefit Plan
PLAN ID. NO.:	43-6001552
PLAN SPONSOR:	City of Hannibal and Board of Public Works 320 Broadway Hannibal, Missouri 63401 573-221-8050 573-221-0111
PLAN NUMBER:	501
TYPE OF PLAN:	Self-funded welfare plan providing dental benefits.
PLAN ADMINISTRATOR:	City of Hannibal and Board of Public Works 320 Broadway Hannibal, Missouri 63401 573-221-8050 573-221-0111
CLAIM ADMINISTRATOR:	RightCHOICE Benefit Administrators 12250 Weber Hill Rd St. Louis, MO 63127-1036 (314) 821-3957
AGENT FOR SERVICE OF LEGAL PROCESS:	City of Hannibal and Board of Public Works 320 Broadway Hannibal, Missouri 63401 573-221-8050 573-221-0111
PLAN YEAR ENDS:	June 30th
FUNDING METHOD:	Employee and Employer contributions

Administered by:

RightCHOICE Benefit Administrators
12250 Weber Hill Rd.
St. Louis, MO 63127

St. Louis Area (314) 821-3957
Toll Free 1-800-365-9036
Fax (314) 821-2532

EFFECTIVE DATE AND SIGNATURES

The effective date of this newly revised and restated Dental Benefit Plan Document and Summary Plan Description is July 1, 2008.

It is agreed by the City of Hannibal and Board of Public Works that the provisions contained in this Plan Document and Summary Plan Description are acceptable and will be the basis for the administration of said Plan described herein.

City of Hannibal	**Board of Public Works**
Signed at Hannibal, Missouri, this 1st day of July 1, 2008.	Signed at Hannibal, Missouri, this 1st day of July 1, 2008.
BY:_____	BY:_____
TITLE:_____	TITLE:_____
WITNESS:_____	WITNESS:_____